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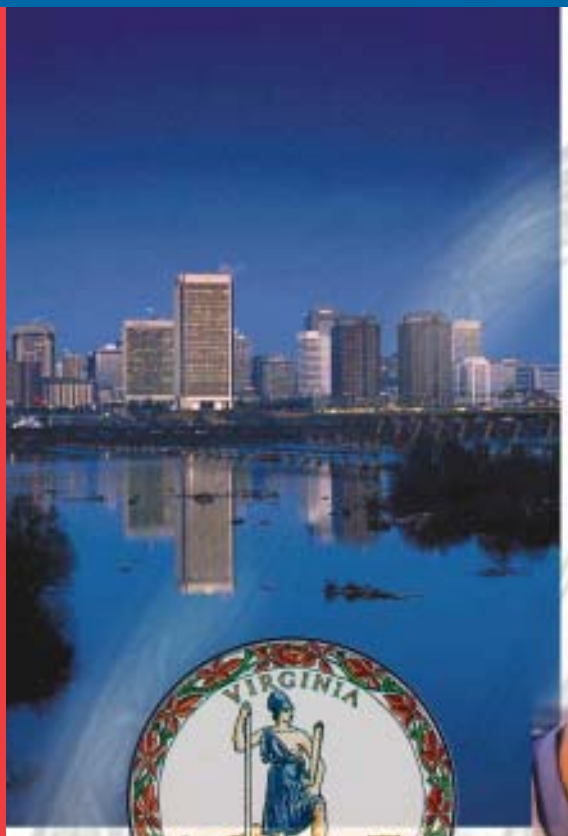

Commonwealth of Virginia Department of Medical Assistance Services

External Quality Review

Anthem HealthKeepers Plus

SFY 2005

We don't provide healthcare... we make it better.

Section I - Operational Systems Review

Introduction

The operational systems review provides an assessment of the structure, process, and outcomes of the MCO's internal operating systems. The purpose is to identify, validate, quantify, and monitor problem areas in the overall quality assurance program. The review incorporated regulations set forth under the Final Rule of the BBA that became effective on August 13, 2002. The BBA is the comprehensive revision to federal statutes governing all aspects of Medicaid managed care programs as set forth in section 1932 of the Social Security Act and title 42 of the *Code of Federal Regulations* (CFR), part 438 et seq. In support of these regulations and MCO contractual requirements, as part of the calendar year (CY) 2004 review, Delmarva evaluated the following systems:

- Enrollee Rights and Protections—Subpart C Regulation
- Quality Assessment and Performance Improvement—Subpart D Regulation
  - Access Standards
  - Structure and Operation Standards
  - Measurement and Improvement Standards
- Grievance Systems—Subpart F Regulation

It is expected that each MCO will utilize the review findings and recommendations found in this report to implement operational systems improvement to become fully compliant with all standards and requirements.

Methodology

The operational systems standards used in the calendar year (CY) 2004 review were the same as those used in the 2003 review period (June through December 2003). These standards incorporate both the BBA and Medallion II contractual requirements. Specifically, in regards to the BBA, these standards include regulations under Subparts C, D, and F of the BBA.

The Operational Systems Review for the period July 2003 through December 2003 was conducted on-site at each MCO. Each element received a compliance rating of "met," "partially met," or "not met." Each element that was not fully met in the 2003 review was assessed as part of the calendar year (CY) 2004 review.

The CY 2004 review of Operational Systems consisted of a desk review of all documents provided by the MCO to assess compliance with all elements that were partially met or not met in the 2003 review. This approach required Delmarva staff to conduct an evaluation of changes to policies, procedures, staff, and processes made by the MCO since the last review. The Delmarva team assessed all documentation provided by the MCO to assess whether or not the MCO' had the administrative and operational systems in place and had implemented key operational policies and procedures to meet statutory requirements. During the process, the reviewers requested and the MCOs were asked to provide additional documentation or clarification where questions or concerns were identified.

As in the 2003 review, Delmarva review staff conducted the review, each element within a standard was rated as "met," "partially met," or "not met". Elements were then rolled up to create a determination of "met", "partially met", or "not met" for each of the standards related to enrollee rights and protections, quality assessment and performance improvement, and grievance system. Table 1 describes this scoring methodology.

Table 1. Rating Scale for Operational Systems Review

Rating	Rating Methodology
Met	All elements within the standard were met
Partially Met	At least half the required elements within the standard were met or partially met
Not Met	Less than half the required elements within the standard were met or partially met

The final element rating was determined as follows. All elements that were met in the 2003 review remained met for the CY 2004 review. All elements that were not fully met (partially met or unmet) were reviewed again and the CY 2004 review determination was applied. Therefore, the Operational Systems Review scores for the CY 2004 should increase from the 2003 year if the MCO made efforts to address the elements that were not fully met in the 2003 review.

Results

The overall performance rating for each of the three major standards is found in Table 2.

Table 2. Operational Systems Review Results by Standard – Calendar Year 2004 Results

Performance Standard	Overall Performance Rating
Subpart C- Enrollee Rights and Protections	Partially Met
Subpart D- Quality Assessment and Performance Improvement	Partially Met
Subpart F- Grievance Systems	Met

A total of 47 standards are evaluated as part of the Operational Systems Review. Of the seven (7) Enrollee Rights standards, six (6) were met and only one (1) was partially met. None of the standards received a review determination of not met. Of the 29 Quality Assessment and Performance Improvement standards, 26 were met and only three (3) were partially met. All 11 Grievance Systems standards were fully met.

Results for each of the 47 Operational Systems Review elements contained within each of the three standards are presented in Table 3. The number of "Met" review determinations is a cumulative sum; it includes the number of elements met in the 2003 review plus those met in the CY 2004 review.

Table3. 2004 Operational Systems Review Results for Anthem Blue Cross/Blue Shield Care

Standard Number	Standard Description	Element Ratings Met/Partially Met/Not Met	Standard Rating
ER 1	Written policies regarding enrollee rights and protections	11/0/0	Met
ER 2	Information provided to enrollees upon enrollment and according to expected time frames	11/0/0	Met
ER 3	Information and language requirements	8/0/0	Met
ER 4	Protected health information	3/0/0	Met
ER 5	Emergency and post-stabilization services	4/0/0	Met
ER 6	Advanced directives	3/1/0	Partially Met
ER 7	Rehabilitation Act, ADA	3/0/0	Met
QA 1	Availability of services: network of appropriate providers	2/0/0	Met
QA 2	Availability of services: direct access to women's health specialist	1/0/0	Met
QA 3	Availability of services: second opinion	1/0/0	Met
QA 4	Availability of services: out of network	1/0/0	Met
QA 5	Cultural considerations	0/1/0	Partially Met
QA 6	Coordination and continuity of care	1/0/0	Met
QA 7	Coordination and continuity of care: additional services for enrollees with special health care needs	1/0/0	Met

Standard Number	Standard Description	Element Ratings Met/Partially Met/Not Met	Standard Rating
QA 8	Direct access to specialists	2/0/0	Met
QA 9	Referrals and treatment plans	1/0/0	Met
QA 10	Primary care and coordination program	3/0/0	Met
QA 11	Coverage and authorization of services: processing of requests	9/0/0	Met
QA 12	Coverage and authorization of services-: notice of adverse action	1/0/0	Met
QA 13	Time frame for decisions: standard authorization decisions	1/0/0	Met
QA 14	Time frame for decisions: expedited authorization decisions	1/0/1	Partially Met
QA 15	Provider selection: credentialing and recredentialing requirements	3/0/0	Met
QA 16	Provider selection: non-discrimination	1/0/0	Met
QA 17	Provider discrimination prohibited	1/0/0	Met
QA 18	Provider selection: excluded providers	1/0/0	Met
QA 19	Provider enrollment and disenrollment: requested by MCO	1/0/0	Met
QA 20	Provider enrollment and disenrollment: requested by the enrollee	2/0/0	Met
QA 21	Grievance systems	4/0/0	Met
QA 22	Subcontractual relationships and delegation	4/0/0	Met
QA 23	Practice guidelines	4/0/0	Met
QA 24	Dissemination of practice guidelines	1/0/0	Met
QA 25	Application of practice guidelines	1/0/0	Met
QA 26	Quality assessment and performance improvement program	2/1/0	Partially Met
QA 27	Under/over utilization of services	1/0/0	Met
QA 28	Care furnished to enrollees with special health needs	1/0/0	Met
QA 29	Health/management information systems	5/0/0	Met
GS 1	Grievance system	8/0/0	Met
GS 2	Filing requirements: procedures	2/0/0	Met
GS 3	Notice of action	1/0/0	Met
GS 4	Content of notice action	6/0/0	Met
GS 5	Record-keeping and reporting requirements	1/0/0	Met
GS 6	Handling of grievances and appeals: special requirements for appeals	6/0/0	Met
GS 7	Resolution and notification: grievances and appeals—standard resolution	2/0/0	Met

Standard Number	Standard Description	Element Ratings Met/Partially Met/Not Met	Standard Rating
GS 8	Resolution and notification: grievances and appeals—expedited appeals	4/0/0	Met
GS 9	Resolution and notification	3/0/0	Met
GS 10	Requirements for state fair hearings	3/0/0	Met
GS 11	Effectuation of reversed appeal resolutions	2/0/0	Met

Scoring for the individual elements can be found in Appendix I-A1, including recommendations for elements that did not achieve full compliance. Detailed findings for each of the 47 review standards by element can be found in Appendix I-A2.

Conclusions and Recommendations

Conclusions

In the overall results Anthem Blue Cross/Blue Shield achieved a score of fully met for 43 of the 47 standards evaluated as part of the review of Enrollee Rights, Quality Assessment, and Grievances systems. A review determination of partially met was achieved for the remaining four (4) standards. None of the 47 standards received a review determination of "Not Met" for the CY 2004 review. Overall, improvement is noted in that 43 standards received a fully met in the CY 2004 review and only 27 standards achieved fully met in the 2003 review.

The specific results of the seven (7) Enrollee Rights standards, indicate that six (6) achieved a score of fully met and one (1) received a score of partially met. Of the 29 Quality Assurance and Performance Improvement standards, 26 achieved a score of fully met and three (3) achieved a score of partially met. Of the 11 Grievance Systems standards, all were fully met.

Recommendations

The recommendations below are a summary of those included in the Detailed Findings section of this report (Appendix IA2). Implementation of these recommendations will facilitate full compliance in the next EQRO review as well as serve to strengthen the MCO's program.

- Anthem Blue Cross/Blue Shield should include language in its Access to Care policy that identifies how enrollees will be informed about the availability of a no-cost second opinion.
- Anthem Blue Cross/Blue Shield must develop written policies and procedures to ensure that there is an ongoing process in place to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds.

- Anthem Blue Cross/Blue Shield needs to add language to existing written policies and procedures to describe the extension time frames for expedited authorizations allowed under the state contract.
- Anthem Blue Cross/Blue Shield must ensure that required reporting to the QIC of quality improvement indicators and subcommittee activity occurs according to the reporting calendar. If there is a reason for delay in reporting, it should be documented in the meeting minutes with the revised date for reporting.

Appendix IA1
Recommendations At-A-Glance

Performance Rating – Virginia EQRO Performance Standards Subpart C Regulations: Enrollee Rights and Protections					
		Met	Partially Met	Not Met	Recommendations To Meet Element
ER1. The MCO has written policies regarding enrollee rights and protections and ensures that staff and affiliated providers take those rights into account when furnishing services					
1.1	Enrollee rights and responsibilities.	X			
1.2	Out of area coverage.	X			
1.3	Restrictions on enrollee's freedom of choice among network providers (431.51).	X			
1.4	Referrals to specialty care (422.113c).	X			
1.5	Enrollee notification – termination/change in benefits, services, or service delivery site.	X			
1.6	Procedures that instruct how to contact enrollee services and a description of the department and its functions.	X			
1.7	Procedures for grievances, appeals, and fair hearing procedures (438.10g, 438.400 – 438.424).	X			
1.8	List of non-English speaking languages spoken by which contracted provider.	X			
1.9	Provider-enrollee communications.	X			
1.10	Procedures for sharing information with enrollees – that they are not liable for payment in case of MCO insolvency.	X			
1.11	Enrollment/ Disenrollment.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart C Regulations: Enrollee Rights and Protections					
		Met	Partially Met	Not Met	Recommendations To Meet Element
ER2. Upon enrollment and according to expected timeframes, enrollees are provided a written statement that includes information on the following (see enrollee materials/brochures):					
2.1	Enrollee rights and responsibilities.				Exempt from the CY 2004 Review
2.2	Enrollee identification cards – descriptions, how and when to use cards.	X			
2.3	All Benefits and services included and excluded as a condition of membership, including authorization requirements and any special benefit provisions that may apply to services obtained outside of the system.	X			
2.4	Procedures for obtaining out-of-area coverage.	X			
2.5	Procedures for restrictions on enrollee's freedom of choice among network providers.	X			
2.6	The MCO's policy on referrals for specialty care.	X			
2.7	Procedures for notifying enrollees affected by the termination or change in benefits, services, or service delivery site.				Exempt from the CY 2004 Review
2.8	Procedures on how to contact enrollee services and a description of the functions of enrollee services.	X			
2.9	Procedures for grievances, appeals, and fair hearing procedures, and the amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart C Regulations: Enrollee Rights and Protections					
		Met	**Partially Met**	**Not Met**	**Recommendations To Meet Element**
2.10	Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the enrollee's service area; include identification of providers that are not accepting new patients. This includes, at a minimum, information on primary care physicians, specialists, and hospitals.	X			
2.11	Procedures for provider-enrollee communications.	X			
2.12	Procedures for providing information on physician incentive plans for those enrollees who request it.	X			
2.13	Process for enrollment and disenrollment from MCO.	X			
ER3. Information and Language requirements (438.10)					
3.1	MCO written enrollee information is available in the prevalent, non-English languages (see DMAS contract) of its particular service area.	X			
3.2	Enrollee information is written in prose that is readable and easily understood.	X			
3.3	State requires Flesch-Kincaid readability of 40 or below (at or below 12th grade level).	X			

Performance Rating – Virginia EQRO Performance Standards Subpart C Regulations: Enrollee Rights and Protections					
		Met	Partially Met	Not Met	Recommendations To Meet Element
3.4	Enrollee vital documents must be translated into non-English languages regularly encountered in the eligible population. Examples of vital documents "Applications, consent forms, letters containing important information about participation in programs (such as a cover letter outlining conditions of participation in a Medicaid managed care program),notices advising LEP persons of the availability of free language assistance."	X			
3.5	MCO has provided written material in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency.	X			
3.6	MCO has policies and procedures in place to make interpretation services available and free of charge to the each potential enrollee and enrollee. This applies to all non-English languages, not just those the State identifies as prevalent.	X			
3.7	MCO has policies and procedures in place to notify its enrollees that oral interpretation is available for any language and written information is available in prevalent languages; and how to access those services.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart C Regulations: Enrollee Rights and Protections					
		Met	**Partially Met**	**Not Met**	**Recommendations To Meet Element**
3.8	MCO has policies and procedures in place to inform enrollees and potential enrollees that information is available in alternative formats and how to access those formats.	**X**			
ER4. 42 C.F.R. 431, Subpart F, and the Code of Virginia, Title 2.1, Chapter 26, (the Privacy Protection Act of 1976) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA).					
4.1	MCO has a confidentiality agreement in place with providers who have access to PHI.	**X**			
4.2	The Contractor shall implement and maintain appropriate safeguards to prevent the use and disclosure of protected health information (PHI).	**X**			
4.3	The Contractor shall make an individual's PHI available to the Department within thirty (30) days of an individual's request for such information as notified and in the format requested by the Department.	**X**			
ER5. Emergency and Post-Stabilization Services (438.114, 422.113c)					
5.1	MCO has policies and procedures in place that define emergency and post-stabilization situations, a description on what to do in an emergency, a telephone number and instructions for obtaining advice on getting care in an emergency, and that prior authorization is not needed.	**X**			
5.2	MCO has given enrollee information on how to utilize after-hours medical advice and enrollee services department.	**X**			

Performance Rating – Virginia EQRO Performance Standards Subpart C Regulations: Enrollee Rights and Protections					
		Met	Partially Met	Not Met	Recommendations To Meet Element
5.3	MCO has processes and procedures in place for obtaining emergency services, including use of the 911-telephone system or its local equivalent.	X			
5.4	MCO has provided enrollees with a description of how to obtain emergency transportation and other medically necessary transportation. (Medical HelpLine Access).	X			
5.5	MCO has provided enrollees with locations of settings that furnish emergency and post-stabilization services covered by MCO.				Exempt from the CY 2004 Review
ER6. Advanced Directives					
6.1	The MCO has provided adult enrollees with written information on advance directives, including a description of the applicable state law.				Exempt for the CY 2004 Review
6.2	MCO has requirements to allow enrollees to participate in treatment decisions/options.	X			
6.3	Procedures to communicate the risks, benefits, and consequences of treatment or non-treatment.	X			
6.4	MCO has policies and procedures to inform enrollees of direct access to women's health specialist within MCO network for routine and preventative care services, as well as a primary care provider.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart C Regulations: Enrollee Rights and Protections					
		Met	Partially Met	Not Met	Recommendations To Meet Element
6.5	MCO has policies and procedures to inform enrollees that they may obtain a second opinion from a qualified health care professional within the network or outside the network if necessary, at no cost to enrollee.		X		Anthem Blue Cross/Blue Shield must include language in the Access to Care policy that identifies how enrollees will be informed about the availability of a no-cost second opinion.
ER7. Rehabilitation Act, ADA					
7.1	MCO is in compliance with Federal and State laws regarding enrollee confidentiality.	X			
7.2	MCO has provided the enrollee with a description of their confidentiality policies.	X			
7.3	MCO has provided enrollee with information on how to obtain a copy of their medical record and how to request records from the MCO.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Not Met	Recommendations To Meet Element
QA1. 438.206 Availability of services (b)					
1.1	MCO has policies and procedures to maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract as evidenced by the following:	X			
1.2	MCO has policies that allow enrollees with disabling conditions, chronic illnesses, or children with special health care needs to request their PCP be a specialist.	X			
QA2. 438.206 Availability of services (b)(2)					
2.1	MCO has policies and procedures to inform enrollees of direct access to women's health specialist within MCO network for routine and preventive care services, as well as a primary care provider.	X			
QA3. 438.206 Availability of services (b)(3)					
3.1	MCO has policies and procedures to provide for a second opinion from a qualified health care professional within the network, or to provide for the enrollee to obtain one outside the network, at no cost to the enrollee.	X			
QA4. 438.206 Availability of services (b)(4)					
4.1	MCO has policies and procedures that provide necessary services out of network, if unable to cover necessary medical services required by enrollee.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Not Met	Recommendations To Meet Element
QA5. 438.206(c) (2) Cultural considerations.					
5.1	The MCO has policies and procedures to promote the delivery of services in a culturally competent manner to all enrollees including those with limited English proficiency and diverse cultural and ethnic backgrounds.		X		Anthem Blue Cross/Blue Shield must develop written policies and procedures to ensure that there is an ongoing process in place to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds.
QA6. 438.208 Coordination and continuity of care.					
6.1	MCO has policies and procedures in place to ensure coordinated care for all enrollees and provide particular attention to needs of enrollees with complex, serious, and/or disabling conditions.	X			
QA7. 438.208(c) 1-3 Coordination and continuity of care – additional services for enrollees with special health care needs					
7.1	The MCO makes a good faith effort to conduct an assessment of enrollees with complex, serious, and/or disabling conditions as identified and reported by the state, within 90 days receipt of notification of SSI children.	X			
QA8. 438.208(c) (4) Direct Access to specialists					
8.1	The MCO has policies and procedures that allow an enrollee with special needs to access a specialist as is appropriate for the condition and identified needs.	X			
8.2	Referral guidelines that demonstrate the conditions under which PCPs make arrangements for referrals to specialty care networks.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Not Met	Recommendations To Meet Element
QA9. 438.208 (d) (2) (ii – iii) Referrals and Treatment Plans					
9.1	The MCO has a mechanism in place for the development of a treatment plan by the specialist in consultation with the enrollee's PCP, with enrollee participation, and is approved in a timely manner.	X			
QA10. 438.208(e) Primary Care and Coordination Program					
10.1	MCO coordinates services furnished to enrollee with those of other MCOs, PHPs, or PAHPs to prevent duplication.	X			
10.2	Coordination of care across settings or transitions in care.	X			
10.3	MCO has policies and procedures to protect enrollee privacy while coordinating care.	X			
QA11. 438.210 (b) Coverage and Authorization of Services - Processing of requests					
11.1	The MCO has policies/procedures in place for processing requests for initial and continuing authorizations of services.	X			
11.2	MCO has policies and procedures in place to ensure that preauthorization requirements do not apply to emergency care, family planning services, preventative services, and basic prenatal care.	X			
11.3	The MCO monitors the application of review criteria for authorizations and takes corrective action to ensure consistent application.	X			
11.4	The MCO has policies and procedures in place for staff to consult with requesting providers when appropriate.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Not Met	Recommendations To Meet Element
11.5	If MCO delegates authorization decisions to subcontractors, the MCO has a mechanism to ensure that standards are met.	X			
11.6	Subcontractor's UM plan is submitted annually and upon revision.	X			
11.7	The MCO has policies and procedures in place that state any decision to deny service authorization requests or to authorize services in an amount, duration, or scope less than requested be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.	X			
11.8	MCO's service authorization decisions are completed within 2 days of receipt of all necessary information.	X			
11.9	MCO is prohibited from providing incentives for denial, limiting, or discontinuing medical services for enrollees.	X			
QA12. 438.210 (c) Coverage and authorization of services - Notice of adverse action.					
12.1	MCO notifies provider and gives written notice of any decision to deny a service authorization request or to authorize as requested.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Not Met	Recommendations To Meet Element
QA13. 438.210 (d) (1) Timeframe for decisions – Standard Authorization Decisions.					
13.1	MCO provides decision notice as expeditiously as enrollee's health condition requires, not to exceed 14 calendar days following receipt of request for service, with possible extension up to 14 additional calendar days if enrollee requests extension or MCO justifies a need for additional information.	X			
QA14. 438.210 (d) (2) Timeframe for decisions – Expedited Authorization Decisions					
14.1	The MCO has policies and procedures to make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than three (3) working days after receipt of the request for service.	X			
14.2	The MCO has policies and procedures relating to the extension time frames for expedited authorizations allowed under the state contract.			X	Anthem Blue Cross/Blue Shield must add language to existing written policies and procedures to describe the extension time frames for expedited authorizations allowed under the state contract.
QA15. 438.214 (b) Provider selection - Credentialing and recredentialing requirements.					
15.1	The MCO has written policies and procedures for selection and retention of providers.	X			
15.2	MCO recredentialing process takes into consideration the performance indicators obtained through QIP, UM program, Grievances and Appeals, and Enrollee satisfaction surveys.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Not Met	Recommendations To Meet Element
15.3	MCO's policies and procedures identify the mechanism for reporting serious quality deficiencies, resulting in suspension or termination of a practitioner, to the appropriate authorities. There is evidence that this process is in place. There is a comprehensive provider appeals process. A review of provider appeals indicates that the process is followed according to policy and procedures.	X			
QA16. 438.214 (c) Provider selection -Nondiscrimination.					
16.1	MCO provider selection policies and procedures do not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.	X			
QA17. 438.12 (a, b) Provider discrimination prohibited					
17.1	For those individual or group providers who are declined, the MCO provides written notice with reason for decision.	X			
QA18. 438.214 (d) Provider Selection – Excluded Providers					
18.1	MCO has policies and procedures and adheres to ineligible provider or administrative entities requirements.	X			
QA19. 438.56 (b) Provider Enrollment and Disenrollment – requested by MCO					
19.1	MCO has policies and procedures that define processes MCO follows when requesting disenrollment, and that the request is in accordance to state contract.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Not Met	Recommendations To Meet Element
QA20. 438.56 (c) Provider Enrollment and Disenrollment – requested by enrollee					
20.1	MCO has policies and procedures in place for enrollees to request disenrollment.	X			
20.2	MCO has policies and procedures and adheres to timeframes established by state for notifying and transitioning enrollees to new PCPs after PCP disenrollment (30 calendar days for each).	X			
QA21. 438.228 Grievance systems					
21.1	MCO has a process for tracking requests for covered services that were denied.	X			
21.2	MCO has process for fair hearing notification.	X			
21.3	MCO has process for provider notification.	X			
21.4	MCO has process for enrollee notification and adheres to state timeframes.	X			
QA22. 438.230 Subcontractual relationships and delegation.					
22.1	MCO evaluates prospective subcontractor's ability to perform the activities to be delegated before delegation occurs.	X			
22.2	MCO has a written agreement that specifies the activities and report responsibilities designated to the subcontractor.	X			
22.3	MCO has a process for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Not Met	Recommendations To Meet Element
22.4	MCO performs an annual review of all subcontractors to evaluate performance and has a mechanism in place to report actions that seriously impact quality of care that may result in suspension/termination of licenses.	X			
QA23. 438.236 (a, b) Practice guidelines.					
23.1	The MCO has adopted practice guidelines that meet current quality standards and the following: a. Are based on valid and reliable clinical evidence or consensus of health care professionals in the particular field. b. Consider the needs of enrollees. c. Are adopted in consultation with contracting health care professionals and d. Are reviewed and updated periodically, as appropriate.				Exempt for the Cy 2004 review
QA24. 438.236 (c) Dissemination of Practice Guidelines					
24.1	The MCO has policies and procedures for the dissemination of guidelines to all affected providers and, upon request, to enrollees and potential enrollees.	X			
QA25. 438.236 (d) Application of Practice Guidelines					
25.1	MCO decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the established guidelines.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Not Met	Recommendations To Meet Element
QA26. 438.240 Quality assessment and performance improvement program					
26.1	MCO has an ongoing quality assessment and performance improvement program for the services provided to this population.		X		Anthem Blue Cross/Blue Shield must ensure that the required reporting to the QIC of quality improvement indicators and subcommittee activity occurs according to the reporting calendar. If there is a reason for a delay in reporting, it should be documented in the meeting minutes with the revised date for reporting.
26.2	MCO is conducting 1 QIP to achieve, through ongoing measurement and interventions, demonstrable and sustained improvement in significant aspects of clinical and non-clinical care that can be expected to have a favorable effect on health outcomes and enrollee satisfaction.	X			
26.3	The MCO corrects significant systemic problems that come to its attention through internal surveillance, complaints, or other mechanisms.	X			
QA27. 438.240 (b) (2) Basic elements of QAPI program – under/over utilization of services					
27.1	MCO's QAPI program has mechanisms to detect both underutilization and over utilization of the MCO services.	X			
QA28. 438.240 (b) (3) Basic elements of QAPI program – care furnished to enrollees with special health needs					
28.1	MCO QAPI program has mechanisms to assess the quality of care and services provided to enrollees with special needs.	X			
QA29. 438.242 Health/Management Information systems.					
29.1	The MCO has information systems capable of furnishing timely, accurate, and complete information about the MCO program.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Not Met	Recommendations To Meet Element
29.2	The MCO information system is capable of: a. Accepting and processing enrollment b. Reconciling reports of MCO enrollment/eligibility c. Accepting and Processing provider claims and encounter data d. Tracking provider network composition, access to services, grievances and appeals e. Performing QI activities	X			
29.3	Furnishing DMAS with timely, accurate, and complete clinical and administrative information.	X			
29.4	MCO ensures that data submitted by providers is accurate by: a. Verifying the accuracy and timeliness of reported data b. Screening the data for completeness, logic, and consistency c. Collecting the service information in standard formats for DMAS d. Assigns unique identifiers to providers and requires that identifiers are used when providers submit data to the MCO	X			
29.5	MCO uses encryption processes to send PHI over the internet.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart F Regulations: Grievance Systems					
		Met	Partially Met	Not Met	Recommendations To Meet Element
GS1. 438.402 (a, b) Grievance System					
1.1	MCO has written policies and procedures that describe the grievance and appeals process and how it operates.	X			
1.2	The definitions for grievances and appeals are consistent with those established by the state 7/03.	X			
1.3	Policies and procedures describe how the MCO intends to receive, track, review, and report all enrollee inquiries, grievances and appeals for the MCO program separately from other programs.	X			
1.4	Policies and procedures describe how MCO responds to grievances and appeals in a timely manner.	X			
1.5	Policies and procedures describe the documentation process and actions taken.	X			
1.6	Policies and procedures describe the aggregation and analysis of the data and use in QI.	X			
1.7	The procedures and any changes to the policies must be submitted to the DMAS annually.	X			
1.8	MCO provides information about grievance and appeals system to all providers and subcontractors.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart F Regulations: Grievance Systems					
		Met	**Partially Met**	**Not Met**	**Recommendations To Meet Element**
GS2. 438.402 (3) Filing Requirements- Procedures					
2.1	The MCO has grievance and appeal forms and provides written procedures to enrollees who wish to register written grievances or appeals.	X			
2.2	The MCO provides reasonable assistance in completing forms and taking other procedural steps including, but not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.	X			
GS3. 438.404 Notice of Action					
3.1	Notice of action is written according to language and format requirements set forth in GS 438.10 Information Requirements	X			
S4. 438.404 (b) Content of Notice Action **Content of NOA explains all of the following:**					
4.1	The action taken and reasons for the action.	X			
4.2	The enrollee's right to file an appeal with MCO.	X			
4.3	The enrollee's right to request a State fair hearing.	X			
4.4	The procedures for exercising appeal rights.	X			
4.5	The circumstances under which expedited resolution is available and how to request an expedited resolution.	X			
4.6	The circumstances under which the enrollee has the right to request that benefits continue pending appeal resolution and the circumstances under which the enrollee may be required to pay the costs of services.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart F Regulations: Grievance Systems					
		Met	**Partially Met**	**Not Met**	**Recommendations To Meet Element**
GS5. 438.416 Record Keeping and reporting requirements					
5.1	The MCO maintains a record keeping and tracking system for inquiries, grievances, and appeals that includes a copy of the original grievance or appeal, the decision, and the nature of the decision.	X			
GS6. 438.406 Handling of grievances and appeals – special requirements for appeals					
6.1	MCO has policies that ensure that individuals who make decisions on grievances and appeals were not involved in previous levels of reviews or decision-making and are health care professionals with appropriate level of expertise in treating the enrollee's condition or disease.	X			
6.2	MCO provides that oral inquires seeking to appeal an action are treated as appeals and confirmed in writing, unless enrollee or provider request expedited resolution.	X			
6.3	MCO provides enrollee with reasonable opportunity to present evidence and allegation of the fact or law in person, as well as in writing.	X			
6.4	MCO informs enrollee of limited time available for cases of expedited resolution.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart F Regulations: Grievance Systems					
		Met	**Partially Met**	**Not Met**	**Recommendations To Meet Element**
6.5	MCO provides enrollee, representative, or legal representation of a deceased enrollee before and during the appeal process, to examine the enrollee case file, including medical records, considered during the appeal process.	**X**			
6.6	MCO continues benefits while appeal or state fair hearing is pending.	**X**			
GS7. 438.408 Resolution and Notification: Grievances and Appeals – Standard Resolution					
7.1	MCO responds in writing to standard appeals as expeditiously as enrollee's health condition requires- not exceeding 30 days from initial date of receipt of the appeal.	**X**			
7.2	In cases of appeals decisions not being rendered within 30 days, MCO provides written notice to enrollee.	**X**			
GS8. 438.408 Resolution and Notification: Grievances and Appeals – Expedited Appeals					
8.1	MCO has an expedited appeal process.	**X**			
8.2	The Contractor shall issue decisions for expedited appeals as expeditiously as the enrollee's health condition requires, not exceeding three (3) working days from the initial receipt of the appeal.	**X**			
8.3	MCO has a process for extension, and for notifying enrollee of reason for delay.	**X**			

Performance Rating – Virginia EQRO Performance Standards Subpart F Regulations: Grievance Systems					
		Met	Partially Met	Not Met	Recommendations To Meet Element
8.4	MCO makes reasonable efforts to provide the enrollee with prompt verbal notice of any decisions that are not resolved wholly in favor of the enrollee and shall follow-up within two calendar days with a written notice of action.	X			
GS9. 438.408 (b -d) Resolution and notification					
9.1	MCO decisions on expedited appeals are in writing and include decision and date of decision.	X			
9.2	For decisions not wholly in favor of enrollee, the MCO provides the enrollee with the right to request a State fair hearing and how to do so, and the right to request to receive benefits while the hearing is pending and how to make the request, explaining that the enrollee may be held liable for the cost of those services if the hearing decision upholds the MCO.	X			
9.3	MCO gives enrollee oral notice of denial and follow up within 2 calendar days with written notice.	X			
GS10. 438.408 (c) Requirements for State Fair Hearings					
10.1	MCO educates enrollees on state's fair hearing process and that appeal must be in writing within 30 days of enrollee's receipt of notice of any action to deny, delay, terminate, or reduce services authorization request.	X			
10.2	MCO provides state with a summary describing basis for denial and for appeal.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart F Regulations: Grievance Systems					
		Met	**Partially Met**	**Not Met**	**Recommendations To Meet Element**
10.3	MCO faxes appeal summaries to state in expedited appeal cases.	X			
GS11. 438.410 Expedited resolution of appeals, GS. 438.424 Effectuation of reversed appeal resolutions					
11.1	The MCO must authorize the disputed services promptly and as expeditiously as the enrollee's health condition requires in cases where MCO or the state fair hearing department reverses a decision to deny, limit, or delay services, in cases where those services were not rendered.	X			
11.2	MCO provides reimbursement for those services in accordance with terms of final agreement by state's appeal division.	X			

Subpart C Regulations: Enrollee Rights and Protections

ER1. The MCO has written policies regarding enrollee rights and protections and ensures that staff and affiliated providers take those rights into account when furnishing services.

Element 1.1 - Enrollee rights and responsibilities.
This element is met.

The Anthem Blue Cross/Blue Shield Members' Rights and Responsibilities Statement Policy, revised March 2005, provides a comprehensive listing of all the enrollee rights required by the Medallion II contract modification dated July 1, 2003. Specifically, the five enrollee rights missing in the prior version of this policy have now been included.

Element 1.2 - Out of area coverage.
This element is previously met - not reviewed.

Element 1.3 - Restrictions on enrollee's freedom of choice among network providers (431.51).
This element is previously met - not reviewed.

Element 1.4 - Referrals to specialty care (422.113c).
This element is previously met - not reviewed.

Element 1.5 - Enrollee notification – termination/change in benefits, services, or service delivery site.
This element is met.

The Anthem Blue Cross/Blue Shield Member Notification of Benefit Changes Policy and Procedures, with an effective date of January 2005, outlines procedures for notifying enrollees of benefit changes through a special mailing and/or an Amendment to the appropriate Evidence of Coverage (EOC). When possible, this notification is to occur 30 calendar days prior to the effective date of the change.

Element 1.6 - Procedures that instruct how to contact enrollee services and a description of department and its functions.
This element is previously met - not reviewed.

Element 1.7 - Procedures for grievances, appeals, and fair hearing procedures (438.10g, 438.400 – 438.424).
This element is previously met - not reviewed.

Element 1.8 - List of non-English languages spoken by contracted providers.
This element is previously met - not reviewed.

Element 1.9 - Provider-enrollee communications.
This element is previously met - not reviewed.

Element 1.10 - Procedures for sharing information with enrollees – that they are not liable for payment in case of MCO insolvency.
This element is met.

The Anthem Blue Cross/Blue Shield Member Communication of Non-Liability for Payment in Case of HMO Insolvency Policy and Procedure, with an effective date of January 2005, requires specific language be included in the EOC informing enrollees they are not liable for payment in case of HMO insolvency. The EOC is provided to members at the time of enrollment. A draft of the EOC, with a revised date of July 2005, supported the inclusion of this language.

Element 1.11 - Process for enrollment and disenrollment from MCO.
This element is met.

Anthem Blue Cross/Blue Shield has developed policies to address inquiries from prospective enrollees as well as MCO initiated termination procedures for existing enrollees. The Anthem Blue Cross/Blue Shield Inquiries from Prospective Members Policy and Procedure details procedures for responding to inquiries from prospective enrollees. The Medicaid Outreach Department is responsible for providing general information about the health plan and plan benefits. Inquiries relating to eligibility and enrollment are referred to the Virginia Medicaid Helpline.

The Anthem Blue Cross/Blue Shield Member Termination Policy and Procedure, with an effective date of April 2005, outlines five events that could result in Anthem Blue Cross/Blue Shield initiating coverage termination such as the enrollee permitting the use of his or her identification card by another person or using another enrollee's card. Separate termination and enrollee and Department of Medical Assistance Services (DMAS) notification procedures are outlined for each of these events.

ER2. Upon enrollment and according to expected timeframes, enrollees are provided a written statement that includes information on the following (see enrollee materials/brochures):

Element 2.1 - Enrollee rights and responsibilities.
This element is exempt for the CY 2004 review.

The Department of Medical Assistance Services has exempted all MCOs from Evidence of Coverage/member handbook requirements for the 2004 review in response to delays experienced by some MCOs in receiving Bureau of Insurance approval of revisions to these documents. Review of this element will be for informational purposes only in assisting Anthem Blue Cross/Blue Shield in meeting this element in the next review.

The Member Handbook and Evidence of Coverage draft, with a revised date of July 2005, provides a comprehensive description of all the enrollee rights required by the Medallion II contract modification dated July 1, 2003. Specifically, the three enrollee rights missing in the prior version of the Member Handbook have now been included. This proposed revision satisfies the requirement of this element.

Element 2.2 - Enrollee identification cards – descriptions and how and when to use cards.
This element is previously met - not reviewed.

Element 2.3 - All benefits and services included and excluded as a condition of membership, including authorization requirements and any special benefit provisions that may apply to services obtained outside of the system.
This element is previously met - not reviewed.

Element 2.4 - Procedures for obtaining out-of-area coverage.
This element is previously met - not reviewed.

Element 2.5 - Procedures for restrictions on enrollee's freedom of choice among network providers.
This element is previously met - not reviewed.

Element 2.6 - The MCO's policy on referrals for specialty care.
This element is previously met - not reviewed.

Element 2.7 - Procedures for notifying enrollees affected by the termination or change in benefits, services, or service delivery site.
This element is exempt for the CY 2004 review.

The Department of Medical Assistance Services has exempted all MCOs from Evidence of Coverage/member handbook requirements for the 2004 review in response to delays experienced by some MCOs in receiving Bureau of Insurance approval of revisions to these documents. Review of this element will be for informational purposes only in assisting Anthem Blue Cross/Blue Shield in meeting this element in the next review.

The Member Handbook and Evidence of Coverage draft, with a revised date of July 2005, includes information on provider terminations under the enrollee right to choose a primary care provider. Enrollees are advised that Anthem Blue Cross/Blue Shield will send them written notification if the PCP they selected terminates his or her relationship with the HMO prior to the effective date of the termination. Procedures are described for assignment of a new PCP. Additionally enrollees are informed of the responsibility of an HMO provider other than the enrollee's PCP to provide direct notification to affected enrollees if the provider terminates his or her relationship with the HMO. The Modifications section advises enrollees that an amendment that specifies any change in benefit will be sent prior to implementation consistent with the policy described in ER 1.5. These proposed revisions satisfy the requirements of this element.

Element 2.8 - Procedures on how to contact enrollee services and a description of the functions of enrollee services.
This element is previously met - not reviewed.

Element 2.9 - Procedures for grievances, appeals, and fair hearing procedures, and the amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled.
This element is previously met - not reviewed.

Element 2.10 - Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the enrollee's service area including identification of providers that are not accepting new patients. This includes, at a minimum, information on primary care physicians, specialists, and hospitals.
This element is previously met - not reviewed.

Element 2.11 - Procedures for provider-enrollee communications.
This element is previously met - not reviewed.

Element 2.12 - Procedures for providing information on physician incentive plans for those enrollees who request it.
This element is previously met - not reviewed.

Element 2.13 - Process for enrollment and disenrollment from MCO.
This element is previously met - not reviewed.

ER3. Information and Language requirements (438.10)

Element 3.1 - MCO written enrollee information is available in the prevalent, non-English languages spoken in its particular service area (see DMAS contract).
This element is previously met - not reviewed.

Element 3.2 - Enrollee information is written in prose that is readable and easily understood.
This element is previously met - not reviewed.

Element 3.3 - State requires Flesch-Kincaid readability of 40 or higher (at or below 12th grade level).
This element is previously met - not reviewed.

Element 3.4 - Enrollee vital documents must be translated into non-English languages regularly encountered in the eligible population. Examples of vital documents include: "Applications, consent forms, letters containing important information about participation in programs (such as a cover letter outlining conditions of participation in a Medicaid managed care program), ...notices advising people with limited English proficiency of the availability of free language assistance."
This element is previously met - not reviewed.

Element 3.5 - MCO has provided written material in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency.
This element is previously met - not reviewed.

Element 3.6 - MCO has policies and procedures in place to make interpretation services available and free of charge to each potential enrollee and enrollee. This applies to all non-English languages, not just those the state identifies as prevalent.
This element is previously met - not reviewed.

Element 3.7 - MCO has policies and procedures in place to notify its enrollees that oral interpretation is available for any language and written information is available in prevalent languages; and how to access those services.
This element is previously met - not reviewed.

Element 3.8 - MCO has policies and procedures in place to inform enrollees and potential enrollees that information is available in alternative formats and how to access those formats.
This element is met.

The Anthem Blue Cross/Blue Shield Written Member Materials in Alternative Formats Policy and Procedure, with an effective date of January 1, 2005, includes language for informing enrollees that written enrollee materials are available in an alternative format. Language to be included in the EOC is identified. Review of the draft of the Member Handbook and EOC, with a revised date of July 2005, evidenced inclusion of this language. Contact numbers for Member Services are provided for assistance in obtaining written material in an alternative format.

ER4. 42 C.F.R. 431, Subpart F, and the Code of Virginia, Title 2.1, Chapter 26, (the Privacy Protection Act of 1976) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Element 4.1 - MCO has a confidentiality agreement in place with providers who have access to PHI.
This element is previously met - not reviewed.

Element 4.2 - The Contractor shall implement and maintain appropriate safeguards to prevent the use and disclosure of protected health information (PHI).
This element is previously met - not reviewed.

Element 4.3 - The Contractor shall make an individual's PHI available to the Department within 30 days of an individual's request for such information as notified and in the format requested by the Department.
This element is met.

The Anthem Blue Cross/Blue Shield and its Affiliated HMOs Medical Management Policy and Procedures on Member Requests for Medical Records, revised January 17, 2005, includes the required language for making an individual's PHI information available to DMAS within thirty (30) days of an individual's request for such information as notified and in the format as requested by the department.

ER5. Emergency and Post-Stabilization Services (438.114, 422.113c)

Element 5.1 - MCO has policies and procedures in place that define emergency and post-stabilization situations, a description on what to do in an emergency, a telephone number and instructions for obtaining advice on getting care in an emergency, and that prior authorization is not needed.
This element is met.

Anthem Blue Cross/Blue Shield has included language in both its policy/procedures and EOC on coverage for post stabilization services to complement existing information on emergency and urgent care services. The Anthem Blue Cross/Blue Shield Medical Management Policy and Procedure on Emergent and Urgent Care Services, revised January 18, 2005, contains language that Anthem Blue Cross/Blue Shield will be responsible for paying all emergency services which are medically necessary including payment for post stabilization. The draft Member Handbook and EOC, with a revised date of July 2005, includes a description of post stabilization services and payment provisions in the section under Emergency and Urgent Care Services. Additionally, the EOC includes explicit instructions for obtaining emergency medical services such as calling 911 or going to the nearest emergency room.

Element 5.2 - MCO has given enrollee information on how to utilize after-hours medical advice and enrollee services department.
This element is previously met - not reviewed.

Element 5.3 - MCO has processes and procedures in place for obtaining emergency services, including use of the 911-telephone system or its local equivalent.
This element is previously met - not reviewed.

Element 5.4 - MCO has provided enrollees with a description of how to obtain emergency transportation and other medical necessary transportation (Medical HelpLine Access).
This element is previously met - not reviewed.

Element 5.5 - MCO has provided enrollees with locations of settings that furnish emergency and post-stabilization services covered by MCO.
This element is exempt for the CY 2004 review.

The Department of Medical Assistance Services has exempted all MCOs from Evidence of Coverage/member handbook requirements for the 2004 review in response to delays experienced by some MCOs in receiving Bureau of Insurance approval of revisions to these documents. Review of this element will be for informational purposes only in assisting Anthem Blue Cross/Blue Shield in meeting this element in the next review.

The draft Member Handbook and EOC, revised July 2005, states that all HMO hospitals provide emergency as well as post stabilization care in the section on Emergency and Urgent Care Services. This revision satisfies the requirement of this element.

ER6. Advanced Directives

Element 6.1 - The MCO has provided adult enrollees with written information on advance directives, including a description of the applicable state law.
This element is exempt for the CY 2004 review.

The Department of Medical Assistance Services has exempted all MCOs from Evidence of Coverage/member handbook requirements for the 2004 review in response to delays experienced by some MCOs in receiving Bureau of Insurance approval of revisions to these documents. Review of this element will be for informational purposes only in assisting Anthem Blue Cross/Blue Shield in meeting this element in the next review.

The draft Member Handbook and EOC, revised July 2005, includes a section entitled Living Will or Power of Attorney which provides a clear description of the two types of enrollee health decisions outlined in the Virginia Health Care Decisions Act. Descriptions of each of these advance directives, Living Will and Power of Attorney, are provided in easily understood language. Enrollees are advised to notify their PCP about their feelings and if they wish to execute a living will or power of attorney for health care. These revisions satisfy the requirements of this element.

Element 6.2 - MCO has requirements to allow enrollees to participate in treatment decisions/options.
This element is previously met - not reviewed.

Element 6.3 - Procedures to communicate the risks, benefits, and consequences of treatment or non-treatment.
This element is previously met - not reviewed.

Element 6.4 - MCO has policies and procedures to inform enrollees of direct access to women's health specialist within MCO network for routine and preventative care services, as well as a primary care provider.
This element is previously met - not reviewed.

Element 6.5 - MCO has policies and procedures to inform enrollees that they may obtain a second opinion from a qualified health care professional within the network or outside the network if necessary, at no cost to enrollee.
This element is partially met.

The Anthem Blue Cross/Blue Shield and its Affiliated HMOs Medical Management Policy and Procedures on Access to Care, revised February 17, 2005, includes language providing for a second

opinion from a qualified health care professional within the network or outside the network if necessary (with approval from Anthem Blue Cross/Blue Shield) at no cost to the enrollee. While the policy does not include procedures for informing enrollees of the availability of a no-cost second opinion review of the draft Member Handbook and EOC, revised July 2005, found a section on Second Opinions that advised enrollees of the availability of a no cost second opinion with a referral from their PCP.

Recommendation:

In order to receive a finding of met in the next EQRO review it is recommended that Anthem Blue Cross/Blue Shield specifically include language in the Access to Care policy that identifies how enrollees will be informed about the availability of a no cost second opinion, such as through the EOC. Subsequent to the review Anthem Blue Cross/Blue Shield submit a revised Access to Care policy that will be assessed for the required language in the next EQR review.

ER7. Rehabilitation Act, ADA

Element 7.1 - MCO complies with Federal and State laws regarding enrollee confidentiality.
This element is previously met - not reviewed.

Element 7.2 - MCO has provided the enrollee with a description of their confidentiality policies.
This element is previously met - not reviewed.

Element 7.3 - MCO has provided enrollee with information on how to obtain a copy of their medical record and how to request records from the MCO.
This element is previously met - not reviewed.

Subpart D Regulations: Quality Assessment and Performance Improvement

QA1. 438.206 Availability of services (b).

Element 1.1 - MCO has policies and procedures to maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract.
This element is previously met - not reviewed.

Element 1.2 - MCO has policies that allow enrollees with disabling conditions, chronic illnesses, or children with special health care needs to request their PCP be a specialist.
This element is previously met - not reviewed.

QA2. 438.206 Availability of services (b)(2).

Element 2.1 - MCO has policies and procedures to inform enrollees of direct access to women's health specialist within MCO network for routine and preventative care services, as well as a primary care provider.
This element is previously met - not reviewed.

QA3. 438.206 Availability of services (b)(3).

Element 3.1 - MCO has policies and procedures to provide for a second opinion from a qualified health care professional within the network, or to provide for the enrollee to obtain one outside the network, at no cost to the enrollee.
This element is met.

As noted in ER 6.5 the Anthem Blue Cross/Blue Shield and its Affiliated HMOs Medical Management Policy and Procedures on Access to Care, revised February 17, 2005, includes language providing for a second opinion from a qualified health care professional within the network or outside the network if necessary (with approval from Anthem Blue Cross/Blue Shield) at no cost to the enrollee.

QA4. 438.206 Availability of services (b)(4)

Element 4.1 - MCO has policies and procedures that provide necessary services out of network, if unable to cover necessary medical services required by enrollee.
This element is previously met - not reviewed.

QA5. 438.206(c)(2) Cultural considerations.

Element 5.1 - The MCO has policies and procedures to promote the delivery of services in a culturally competent manner to all enrollees including those with limited English proficiency and diverse cultural and ethnic backgrounds.
This element is partially met.

Consistent with the 2003 review findings there were no written policies and procedures to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds. As in the 2003 review Anthem Blue Cross/Blue Shield submitted a Cultural and Linguistic Report for Anthem Blue Cross/Blue Shield Health Plans in Virginia for 2005. This report was developed to comply with two NCQA requirements regarding the cultural and linguistic needs of the plan's enrollee population. While it is evident that Anthem Blue Cross/Blue Shield is assessing the cultural and linguistic needs of its enrollees and developing interventions as appropriate this report is insufficient in meeting the requirements of this element.

Recommendations:
In order to receive a finding of met in the next EQRO review Anthem Blue Cross/Blue Shield must develop written policies and procedures to ensure that there is an on-going process in place to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds.

QA6. 438.208 Coordination and continuity of care.

Element 6.1 - MCO has policies and procedures in place to ensure coordinated care for all enrollees and provide particular attention to needs of enrollees with complex, serious, and/or disabling conditions.
This element is met.

In response to the 2003 review findings Anthem Blue Cross/Blue Shield has revised its Case Management policy to address coordination of care for enrollees with special needs. This policy outlines procedures for coordinating care for enrollees diagnosed with chronic illness, acute catastrophic illness, or complex care needs. Procedures include developing an individualized plan of care in collaboration

with the enrollee, family, PCP, attending physician, and ancillary health care providers and coordinating and facilitating the implementation of the plan.

QA7. 438.208(c) 1-3 Additional services for enrollees with special health care needs.

Element 7.1 - The MCO makes a good faith effort to conduct an assessment of enrollees with complex, serious, and/or disabling conditions as identified and reported by the state, within 90 days receipt of notification of SSI children.
This element is met.

The Children with Special Health Care Needs Program Description – 2003 provides for a thorough risk assessment for those children meeting eligibility requirements within 90 days of enrollment into the MCO.

QA8. 438.208(c) (4) Direct access to specialists.

Element 8.1 - The MCO has policies and procedures that allow an enrollee with special needs to access a specialist as is appropriate for the condition and identified needs.
This element is previously met - not reviewed.

Element 8.2 - Referral guidelines that demonstrate the conditions under which PCPs arrange for referrals to specialty care networks.
This element is previously met - not reviewed.

QA9. 438.208 (d) (2) (ii – iii) Referrals and treatment plans.

Element 9.1 - The MCO has a mechanism in place for the development of a treatment plan by the specialist in consultation with the enrollee's PCP, with enrollee participation, and is approved in a timely manner.
This element is previously met - not reviewed.

QA10. 438.208(e) Primary care and coordination program.

Element 10.1 - MCO coordinates services furnished to enrollee with those of other MCOs, PIHP, PAHP to prevent duplication.
This element is met.

The Anthem Blue Cross/Blue Shield and its Affiliated HMOs Medical Management Policy and Procedure: Transition of Care was revised January 2005 to incorporate required language addressing duplication of services. Procedures include Anthem Blue Cross/Blue Shield Medical Management staff verifying with the ordering provider that the member is enrolled with the current MCO (Anthem Blue Cross/Blue Shield) and ascertaining if previous care had/has been rendered for the services provider is ordering by the previous MCO or DMAS.

Element 10.2 - Coordination of care across settings or transitions in care.
This element is previously met - not reviewed.

Element 10.3 - MCO has policies and procedures to protect enrollee privacy while coordinating care.
This element is previously met - not reviewed.

QA11. 438.210 (b) Coverage and authorization of services - processing of requests.

Element 11.1 - The MCO has policies/procedures in place for processing requests for initial and continuing authorizations of services.
This element is previously met - not reviewed.

Element 11.2 - MCO has policies/procedures in place to ensure that preauthorization requirements do not apply to emergency care, family planning services, preventive services and basic prenatal care.
This element is previously met - not reviewed.

Element 11.3 - The MCO monitors the application of review criteria for authorizations and takes corrective action to ensure consistent application.
This element is previously met - not reviewed.

Element 11.4 - The MCO has policies/procedures in place for staff to consult with requesting providers when appropriate.
This element is previously met - not reviewed.

Element 11.5 - If MCO delegates authorization decisions to subcontractors, the MCO has a mechanism to ensure that standards are met.

This element is previously met - not reviewed.

Element 11.6 - Subcontractor's utilization management plan is submitted annually and upon revision.

This element is previously met - not reviewed.

Element 11.7 - The MCO has policies/procedures in place that state any decision to deny service authorization requests or to authorize services in an amount, duration, or scope less than requested be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.

This element is previously met - not reviewed.

Element 11.8 - MCO's service authorization decisions are completed within 2 days of receipt of all necessary information.

This element is previously met - not reviewed.

Element 11.9 - MCO is prohibited from providing incentives for denial, limiting, or discontinuing medical services for enrollees.

This element is previously met - not reviewed.

QA12. 438.210 (c) Coverage and authorization of services - notice of adverse action.

Element 12.1 MCO notifies provider and gives written notice of any decision to deny a service authorization request or to authorize as requested.

This element is previously met - not reviewed.

QA13. 438.210 (d) (1) Timeframe for decisions – standard authorization decisions.

Element 13.1 - MCO provides decision notice as expeditiously as enrollee's health condition requires, not exceeding 14 calendar days following receipt of request for service, with possible extension up to 14 additional calendar days if enrollee requests extension or MCO justifies a need for additional information.

This element is previously met - not reviewed.

QA14. 438.210 (d) (2) Timeframe for decisions – expedited authorization decisions.

Element 14.1 - The MCO has policies/procedures to make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than three working days after receipt of the request for service.
This element is previously met - not reviewed.

Element 14.2 - The MCO has policies/procedures relating to the extension time frames for expedited authorizations allowed under the state contract.
This element is not met.

The 2003 review found that Anthem Blue Cross/Blue Shield did not have a process that described how Anthem Blue Cross/Blue Shield receives requests for extensions on expedited service requests in the policies submitted. In response to these findings Anthem Blue Cross/Blue Shield provided three Medical Management Desktop Procedures: Lack of Information Prospective and Retrospective, Voided vs. Cancelled TriMed Medical Records (TMR), and When to Start a New Outpatient Preauthorization TMR. None of these procedures addressed the requirement outlined in the Medallion II Managed Care Contract, dated July 1, 2003 which states that the Contractor may extend the three (3) working days turnaround time frame (for expedited authorization decisions) by up to fourteen (14) calendar days if the enrollee requests an extension or the Contractor justifies to the Department a need for additional information and how the extension is in the enrollee's interest.

Recommendations:
In order to receive a finding of met in the next EQRO review Anthem Blue Cross/Blue Shield needs to add language to existing written policies and procedures to describe the extension time frames for expedited authorizations allowed under the state contract.

QA15. 438.214 (b) Provider selection - credentialing and recredentialing requirements.

Element 15.1 - The MCO has written policies/procedures for selection and retention of providers using 2003 NCQA guidelines.
This element is previously met - not reviewed.

Element 15.2 - MCO recredentialing process takes into consideration the performance indicators obtained through quality improvement projects (QIPs), utilization management program, grievances and appeals, and enrollee satisfaction surveys.
This element is previously met - not reviewed.

This element received a finding of partially met in the 2003 onsite review. In response to this finding Anthem Blue Cross/Blue Shield has provided the Anthem Blue Cross/Blue Shield Practitioner Complaint History Monitoring Policy and Procedures, revised March 2005 that requires documentation of all actions taken relating to a practitioner and history of issues/complaints be filed in the credentialing file. The Performance Appraisal of Primary Care Providers policy reviewed in 2003 was reported to have been inactivated in 1999. In order to assess compliance with this element a review of recredentialing files is required to ensure that Anthem Blue Cross/Blue Shield is in compliance with its policies to incorporate performance indicators in the recredentialing process. Since a file review is outside of the scope of this desktop review recredentialing files will be requested during the next onsite review.

Element 15.3 - MCO's policies and procedures identify the mechanism for reporting serious quality deficiencies, resulting in suspension or termination of a practitioner, to the appropriate authorities. There is evidence that this process is in place. There is a comprehensive provider appeals process. A review of provider appeals indicates that the process is followed according to policy and procedures.
This element is previously met - not reviewed.

QA16. 438.214 (c) Provider selection -nondiscrimination.

Element 16.1 - MCO provider selection policies and procedures do not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.
This element is previously met - not reviewed.

QA17. 438.12 (a, b) Provider discrimination prohibited.

Element 17.1 - For those individual or group providers who are declined, the MCO provides written notice with reason for decision.
This element is previously met - not reviewed.

QA18. 438.214 (d) Provider Selection – excluded providers.

Element 18.1 - MCO has policies/procedures and adheres to ineligible provider or administrative entities requirements set forth in K. Provider Relations.
This element is previously met - not reviewed.

QA19. 438.56 (b) Provider enrollment and disenrollment – requested by MCO.

Element 19.1 - MCO has policies/procedures that define processes MCO follows when requesting disenrollment, and that the request is in accordance to state contract.
This element is previously met - not reviewed.

QA20. 438.56 (c) Provider enrollment and disenrollment – requested by enrollee.

Element 20.1 - MCO has policies/procedures in place for enrollees to request disenrollment.
This element is previously met - not reviewed.

Element 20.2 - MCO has policies/procedures and adheres to time frames established by state for notifying and transitioning enrollees to new PCPs after PCP disenrollment (30 calendar days for each).
This element is previously met - not reviewed.

QA21. 438.228 Grievance systems.

Element 21.1 - MCO has a process for tracking requests for covered services that were denied
This element is met.

Based upon findings from the 2003 review Anthem Blue Cross/Blue Shield was required to demonstrate procedures for tracking requests for covered services that were denied. In response to these findings Anthem Blue Cross/Blue Shield has submitted results from quarterly inter-rater reliability assessments of its review staff and sample results from a quarterly denial file audit conducted in 2004. The 4th Quarter Denial File Audit Summary included 15 HMO medical and 14 HMO pharmacy denial files from October 1, 2003 through December 31, 2003. According to Anthem Blue Cross/Blue Shield staff this file includes both commercial and Medicaid enrollees. The purpose of this audit was to assess compliance with NCQA standards. Among the areas reviewed were compliance with requirements for physician review of denials, timeliness of denial decisions, notification of denial decision, clinical information to support denial decision, physician availability to discuss denial, denial letter reasons, basis of decision, and notice of appeal rights. Minutes from the Medical Management Committee meeting evidenced review and discussion of these findings. Additionally, focused audits were reviewed and discussed to assess if correct determinations were made related to requests for services such as inpatient admission for morbid obesity and gastroenteritis.

Element 21.2 - MCO has process for fair hearing notification.

This element is previously met - not reviewed.

Element 21.3 - MCO has process for provider notification.

This element is previously met - not reviewed.

Element 21.4 - MCO has process for enrollee notification and adheres to state time frames.

This element is previously met - not reviewed.

QA22. 438.230 Subcontractual relationships and delegation.

Element 22.1 - MCO evaluates prospective subcontractor's ability to perform the activities to be delegated before delegation occurs.

This element is previously met - not reviewed.

Element 22.2 - MCO has a written agreement that specifies the activities and report responsibilities designated to the subcontractor.

This element is previously met - not reviewed.

Element 22.3 - MCO has a process for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.

This element is previously met - not reviewed.

Element 22.4 - MCO performs an annual review of all subcontractors to evaluate performance and has a mechanism in place to report actions that seriously impact quality of care that may result in suspension/termination of licenses.

This element is previously met - not reviewed.

QA23. 438.236 (a, b) Practice guidelines.

Element 23.1 - The MCO has adopted practice guidelines that meet current NCQA standards and the following:

a) Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.

This component is previously met - not reviewed.

b) Consider the needs of the enrollees.
This component is previously met - not reviewed.

c) Are adopted in consultation with contracting health care professionals.
This component is previously met - not reviewed.

d) Are reviewed and updated periodically, as appropriate.
This component is previously met - not reviewed.

QA24. 438.236 (c) Dissemination of practice guidelines.

Element 24.1 - The MCO has policies/procedures for the dissemination of guidelines to all affected providers and, upon request, to enrollees and potential enrollees.
This element is met.

In the last review it was noted that there was no evidence of procedures for sharing guidelines with enrollees upon request. In response to the 2003 findings Anthem Blue Cross/Blue Shield submitted the Clinical Practice Guideline Development and Monitoring Policy and Procedures, revised March 2005. This policy requires Anthem Blue Cross/Blue Shield to annually distribute preventive health screening guidelines and any updates that are approved by the Quality Improvement Committee to members. Means of communication may include enrollee newsletters, the Anthem Blue Cross/Blue Shield website, and special mailings.

The draft Member Handbook and EOC, revised July 2005, advises enrollees that they may obtain a copy of Anthem Blue Cross/Blue Sheild's clinical practice guidelines by contacting Member Services with appropriate contact numbers provided.

QA25. 438.236 (d) Application of practice guidelines.

Element 25.1 - MCO decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the established guidelines.
This element is previously met - not reviewed.

QA26. 438.240 Quality assessment and performance improvement program.

Element 26.1 - MCO has an ongoing quality assessment and performance improvement program for the services provided to this population.
This element is partially met.

This element was partially met in 2003 based upon lack of documentation in Quality Improvement Committee minutes of required reporting of quality improvement indicators and subcommittee activity according to the reporting calendar. In response to these findings Anthem Blue Cross/Blue Shield has submitted sample minutes from six Quality Improvement Committee meetings held in 2004, which reflect reporting of quality improvement indicators and subcommittee reports. Reporting, however, is often not consistent with the time frames identified on the reporting calendar. For example, minutes from the December 7, 2004 meeting documented review and approval of both 2nd and 3rd quarter reports from the Medical Management Committee, Provider Review Council, Credentialing Committee, and the Managed Care Advisory Panel. Delaying reports by several months as demonstrated in this example does not allow the QIC to provide effective oversight of subcommittee activities.

Recommendations:
As recommended in the 2003 review in order to receive a finding of met in the next review Anthem Blue Cross/Blue Shield needs to ensure that required reporting to the QIC of quality improvement indicators and subcommittee activity occurs according to reporting calendar. If there is a reason for a delay in reporting, it should be documented in the meeting minutes with the revised date for reporting. In no case, however, should a report be several months late.

Element 26.2 - MCO is conducting 1 QIP to achieve, through ongoing measurement and interventions, demonstrable and sustained improvement in significant aspects of clinical and non-clinical care that can be expected to have a favorable effect on health outcomes and enrollee satisfaction.
This element is previously met - not reviewed.

Element 26.3 - The MCO corrects significant systemic problems that come to its attention through internal surveillance, complaints, or other mechanisms.
This element is met.

This element was scored as partially met in the 2003 review based upon a lack of documentation that supported Anthem Blue Cross/Blue Shield implementing corrective action to achieve meaningful improvement in significant systemic problems identified through its quality improvement process. As evidence of compliance Anthem Blue Cross/Blue Shield has submitted documentation supporting a change in transportation vendors to address longstanding complaints relating to the transportation

vendor. Anthem Blue Cross/Blue Shield has also provided additional examples of activities to address identified opportunities for improvement. For example, in late 2004 Service Operations implemented One Touch Service that enables Member Service Representatives to follow up with an enrollee requesting a change in their PCP once the eligibility file is received rather than asking the enrollee to call back after the DMAS eligibility file is received. Reduction in call volume and an increase in enrollee satisfaction have been attributed to this change. As part of the next on-site review QIC meeting minutes will be reviewed to ensure that Anthem Blue Cross/Blue Shield is consistent in implementing corrective action for significant systemic issues based upon a root cause analysis and monitoring interventions to determine their effectiveness.

QA27. 438.240 (b) (2) Basic elements of QAPI program – under/over utilization of services.

Element 27.1 - MCO's QAPI program has mechanisms to detect both underutilization and overutilization of the Medallion II services.
This element is met.

In response to the 2003 review findings Anthem Blue Cross/Blue Shield submitted evidence that over and under utilization data is reported at least annually to the Medical Management Committee and that routine reports are submitted to the QIC. The Medical Management Committee minutes of March 16, 2004 documented review of the 2003 Over and Under Utilization Report. It was concluded that all indicators monitored were within threshold; however, a discussion of changes to the indicators relating to borderline problem areas, such as Emergency Room visits, was planned for the following meeting. The QIC minutes from May 18, 2004 documented review and approval of the first quarter Medical Management Committee Report and the December 7, 2004 minutes documented review and approval of the second and third quarter Medical Management Committee Reports.

QA28. 438.240 (b) (3) Basic elements of QAPI program – care furnished to enrollees with special health needs.

Element 28.1 - MCO QAPI program has mechanisms to assess the quality of care and services provided to enrollees with special needs.
This element is previously met - not reviewed.

QA29. 438.242 Health/management information systems.

Element 29.1 - The MCO has information systems capable of furnishing timely, accurate, and complete information about the Medallion II program.
This element is previously met - not reviewed.

Element 29.2 - The MCO information system is capable meeting requirements.
This element is previously met - not reviewed.

Element 29.3 - Furnishing DMAS with timely, accurate and complete clinical and administrative information.
This element is previously met - not reviewed.

Element 29.4 - MCO ensures that data submitted by providers are accurate by meeting requirements.
This element is previously met - not reviewed.

Element 29.5 - MCO uses encryption processes to send PHI over the Internet
This element is previously met - not reviewed.

Subpart F Regulations: Grievance Systems

GS1. 438.402 (a, b) Grievance system.

Element 1.1 - MCO has written policies and procedures that describe the grievance and appeals process and how it operates.
This element is previously met - not reviewed.

Element 1.2 - The definitions for grievances and appeals are consistent with those established by the state in July 2003.
This element is previously met - not reviewed.

Element 1.3 - Policies/procedures describe how the MCO intends to receive, track, review, and report all enrollee inquiries, grievances and appeals for the Medallion II program separately from the commercial program.
This element is previously met - not reviewed.

Element 1.4 - Policies/procedures describe how MCO responds to grievances and appeals in a timely manner.
This element is previously met - not reviewed.

Element 1.5 - Policies/procedures describe the documentation process and actions taken.
This element is previously met - not reviewed.

Element 1.6 - Policies/procedures describe the aggregation and analysis of the data and use in quality improvement.
This element is previously met - not reviewed.

Element 1.7 - The procedures and any changes to the policies/procedures must be submitted to the DMAS annually.
This element is previously met - not reviewed.

Element 1.8 - MCO provides information about grievance and appeals system to all providers and subcontractors.
This element is previously met - not reviewed.

GS2. 438.402 (3) Filing requirements- procedures.

Element 2.1 - The MCO has grievance and appeal forms and provides written procedures to enrollees who wish to register written grievances or appeals.
This element is previously met - not reviewed.

Element 2.2 - The MCO provides reasonable assistance in completing forms and taking other procedural steps including, but not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.
This element is previously met - not reviewed.

GS3. 438.404 Notice of action.

Element 3.1 - Notice of action is written according to language and format requirements set forth in GS. 438.10 Information Requirements.
This element is previously met - not reviewed.

GS4. 438.404 (b) Content of notice of action.
Content of NOA explains all of the following:

Element 4.1 - The action taken and reasons for the action.
This element is previously met - not reviewed.

Element 4.2 - The enrollee's right to file an appeal with MCO.
This element is previously met - not reviewed.

Element 4.3 - The enrollee's right to request a state fair hearing.
This element is previously met - not reviewed.

Element 4.4 - The procedures for exercising appeal rights.
This element is previously met - not reviewed.

Element 4.5 - The circumstances under which expedited resolution is available and how to request an expedited resolution.
This element is previously met - not reviewed.

Element 4.6 - The circumstances under which the enrollee has the right to request that benefits continue pending appeal resolution and the circumstances under which the enrollee may be required to pay the costs of services.
This element is previously met - not reviewed.

GS5. 438.416 Record keeping and reporting requirements.

Element 5.1 - The MCO maintains a record keeping and tracking system for inquiries, grievances, and appeals that includes a copy of the original grievance or appeal, the decision, and the nature of the decision.
This element is previously met - not reviewed.

GS6. 438.406 Handling of grievances and appeals – special requirements for appeals.

Element 6.1 - MCO has policies that ensure that individuals who make decisions on grievances and appeals were not involved in previous levels of reviews or decision-making and are health care professionals with appropriate level of expertise in treating enrollee's condition or disease.
This element is met.

The Anthem Blue Cross/Blue Shield Member Complaint Policy and Procedure, revised May 2005, requires individuals making decisions on complaints to have had no involvement in previous levels of reviews or decision-making. The revision of this policy is consistent with a similar provision included in the Anthem Blue Cross/Blue Shield Member Appeal Policy and Procedure.

Element 6.2 - MCO provides that oral inquires seeking to appeal an action are treated as appeals and confirmed in writing, unless enrollee or provider request expedited resolution.
This element is previously met - not reviewed.

Element 6.3 - MCO provides enrollee with reasonable opportunity to present evidence and allegation of the fact or law in person, as well as in writing.
This element is met.

The Anthem Blue Cross/Blue Shield Member Appeal Policy and Procedure, revised May 2005, includes a provision for the enrollee or the appointed authorized representative acting on behalf of the enrollee to submit comments, documents, and other information pertinent to the pre-service or post-service appeal. This information can be presented in person, orally or it writing.

Element 6.4 - MCO informs enrollee of limited time available for cases of expedited resolution.
This element is previously met - not reviewed.

Element 6.5 - MCO provides enrollee, representative, or legal representation of a deceased enrollee before and during the appeal process, to examine the enrollee case file, including medical records, considered during the appeal process.
This element is previously met - not reviewed.

Element 6.6 - MCO continues benefits while appeal or state fair hearing is pending.
This element is previously met - not reviewed.

GS7. 438.408 Resolution and notification: grievances and appeals – standard resolution.

Element 7.1 - MCO responds in writing to standard appeals as expeditiously as enrollee's health condition requires-not exceeding 30 days from initial date of receipt of the appeal.
This element is previously met - not reviewed.

Element 7.2 - In cases of appeal decisions not being rendered within 30 days, MCO provides written notice to enrollee.
This element is previously met - not reviewed.

GS8. 438.408 Resolution and notification: grievances and appeals – expedited appeals.

Element 8.1 - MCO has an expedited appeal process.
This element is previously met - not reviewed.

Element 8.2 - The Contractor shall issue decisions for expedited appeals as expeditiously as the enrollee's health condition requires, not exceeding three working days from the initial receipt of the appeal.
This element is previously met - not reviewed.

Element 8.3 - MCO has a process for extension, and for notifying enrollees of reason for delay.
This element is met.

The Anthem Blue Cross/Blue Shield Member Appeal Policy and Procedure, revised May 2005, includes a provision for written notification of an enrollee if the MCO requires the additional 14 days to resolve the appeal. This notification is to include the reason for the extension.

Element 8.4 - MCO makes reasonable efforts to provide the enrollee with prompt verbal notice of any decisions that are not resolved wholly in favor of the enrollee and shall follow-up within two calendar days with a written notice of action.
This element is previously met - not reviewed.

GS9. 438.408 (b -d) Resolution and notification.

Element 9.1 - Decisions by the MCO to expedite appeals are in writing and include decision and date of decision.
This element is previously met - not reviewed.

Element 9.2 - For decisions not wholly in favor of enrollee, the MCO provides the enrollee with the hearing is pending and how to make the request, explaining that the enrollee may be held liable for the right to request a state fair hearing and how to do so, and the right to request to receive benefits while the cost of those services if the hearing decision upholds the MCO.
This element is previously met - not reviewed.

Element 9.3 - MCO gives enrollee oral notice of denial and follow up within 2 calendar days with written notice.
This element is previously met - not reviewed.

GS10. 438.408 (c) Requirements for state fair hearings.

Element 10.1 - MCO educates enrollees on state's fair hearing process and that appeal must be in writing within 30 days of enrollee's receipt of notice of any action to deny, delay, terminate, or reduce services authorization request.
This element is previously met - not reviewed.

Element 10.2 - MCO provides state with a summary describing basis for denial and for appeal.
This element is previously met - not reviewed.

Element 10.3 - MCO faxes appeal summaries **to** state in expedited appeal cases.
This element is met.

The Anthem Blue Cross/Blue Shield Member Appeal Policy & Procedures includes procedures for faxing appeal summaries to DMAS for expedited desktop review in the section on Anthem Blue Cross/Blue Shield (Medicaid and FAMIS) members.

GS11. 438.410 Expedited resolution of appeals, GS. 438.424 effectuation of reversed appeal resolutions.

Element 11.1 - The MCO must authorize the disputed services promptly and as expeditiously as the enrollee's health condition requires in cases where MCO or State Fair Hearing Department reverses a decision to deny, limit, or delay services, in cases where those services were not rendered.
This element is previously met - not reviewed.

Element 11.2 - MCO provides reimbursement for those services in accordance with terms of final agreement by state's appeal division.
This element is previously met - not reviewed.

Summary of Documents Reviewed		
Element	**Document**	**Date**
ER 1	Anthem Blue Cross/Blue Shield Members' Rights and Responsibilities Statement Policy	03/2005 revised
	Anthem Blue Cross/Blue Shield Member Notification of Benefit Changes Policy and Procedure	01/2005 effective date
	Anthem Blue Cross/Blue Shield Member Communication of Non-Liability for Payment in Case of HMO Insolvency Policy and Procedure	01/2005 effective date
	Member Handbook and Evidence of Coverage (draft)	07/2005
	Anthem Blue Cross/Blue Shield Inquiries from Prospective Members Policy and Procedure	01/2005 effective date
	Anthem Blue Cross/Blue Shield Member Termination Policy and Procedure	04/2005 effective date
ER 2	Member Handbook and Evidence of Coverage (draft)	07/2005
ER 3	Member Handbook and Evidence of Coverage (draft)	07/2005
	Anthem Blue Cross/Blue Shield Written Member Materials in Alternative Formats Policy and Procedure	01/2005 effective date
ER 4	Anthem Blue Cross/Blue Shield and its Affiliated HMOs Medical Management Policy and Procedure: Member Requests for Medical Records	01/17/2005 revised
ER 5	Anthem Blue Cross/Blue Shield and its Affiliated HMOs Medical Management Policy and Procedure: Emergent and Urgent Care Services	01/17/2005 revised
	Member Handbook and Evidence of Coverage (draft)	07/2005
ER 6	Member Handbook and Evidence of Coverage (draft)	07/2005
	Anthem Blue Cross/Blue Shield and its Affiliated HMOs Medical Management Policy and Procedure: Access to Care	02/17/2005 revised
QA 3	Anthem Blue Cross/Blue Shield and its Affiliated HMOs Medical Management Policy and Procedure: Access to Care	02/17/2005 revised
QA 5	2005 Cultural and Linguistic Report for Anthem Blue Cross/Blue Shield Health Plans in Virginia	04/2005
QA 6	Anthem Blue Cross/Blue Shield and its Affiliated HMOs Medical Management Policy and Procedure: Case Management	01/17/2005 revised
QA 7	Children with Special Health Care Needs Program Description- 2003	Undated
QA 10	Anthem Blue Cross/Blue Shield and its Affiliated HMOs Medical Management Policy and Procedure: Transition of Care	01/17/2005 revised
QA 14	Medical Management Desktop Procedure: Voided vs. Canceled TriMed Medical Records (TMR)	02/22/2005 revised
	Medical Management Desktop Procedure: Lack of Information Prospective and Retrospective	06/10/2002 revised
	Medical Management Desktop Procedure: When To Start a New Outpatient Preauthorization TMR	02/05/2004 revised
QA 15	Anthem Blue Cross/Blue Shield Practitioner Complaint History Monitoring Policy and Procedure	03/2005 revised
	Anthem Blue Cross/Blue Shield Member Complaint Policy and Procedure (draft)	05/2005
QA 21	Medical Management Inter-Rater Reliability 4th Quarter 2004	Undated
	Medical Management Inter-Rater Reliability 4th Quarter 2003	Undated
	Medical Management Inter-Rater Reliability 2nd Quarter 2004	Undated
	4th Quarter Denial File Audit Summary Report	03/11/2004
	Anthem Blue Cross/Blue Shield Southeast Medical Management	08/17/2004,

Summary of Documents Reviewed		
Element	**Document**	**Date**
	Committee minutes	11/16/2004, 12/14/2004
QA 24	Member Handbook and Evidence of Coverage (draft)	07/2005
	Anthem Blue Cross/Blue Shield Clinical Practice Guideline Development and Monitoring Policy and Procedures	03/2005 revised
QA 26	Emphasis on One Touch Service	Undated
	Anthem Blue Cross/Blue Shield Professional Forum (provider newsletter)	02/2005
	Print screen of the training/resource website for Member Services	05/02/2005
	QIC Meeting Minutes	02/03/2004, 03/02/2004, 05/18/2004, 08/03/2004, 10/05/2004, 12/07/2004
	2005 QI Committee/Subcommittee Schedule	Undated
QA 27	QIC Meeting Minutes	05/18/2004, 12/07/2004
	Medical Management Committee minutes	03/16/2004
	2003 Over and Under Utilization Report	12/2003
GS6	Anthem Blue Cross/Blue Shield Member Complaint Policy and Procedure	05/2005 revised
	Anthem Blue Cross/Blue Shield Member Appeal Policy and Procedure	05/2005 revised
GS 8	Anthem Blue Cross/Blue Shield Member Appeal Policy and Procedure	05/2005 revised
GS 10	Anthem Blue Cross/Blue Shield Member Appeal Policy and Procedure	05/2005 revised